

Integrated Healthcare & Supportive Housing

A Report on a PCDC/CSH Market Assessment & Convening



ACKNOWLEDGEMENTS

Integrated Healthcare and Supportive Housing: A Report on a PCDC/CSH Market Assessment and Convening April 24, 2014

Over the past year, the Primary Care Development Corporation (PCDC) and CSH have collaborated on a project to explore capital development resource needs to advance development of healthcare and supportive partnerships. Findings from our market assessment and interviews with stakeholders led us to the conclusion that there is a need to further facilitate the relationships that will advance cross-sector collaborations. The **Integrated Healthcare and Supportive Housing Convening** brought together a diverse set of providers to share successes, challenges and recommendations for taking this work to scale. We extend our thanks to the Convening Participants and their Agencies, for the work they do in their communities, and for their contributions at the Convening. Convening Participants and their Agencies are identified in the Appendix to this report.

Our sincere gratitude is extended to **Fred Karnas**, Social Investment Officer with **The Kresge Foundation**, for his knowledge, dedication, and able facilitation at the Integrated Healthcare and Supportive Housing Convening. Funding for the Integrated Healthcare and Supportive Housing Market Assessment and Convening was generously provided by The Kresge Foundation. The Kresge Foundation works to expand opportunities in America's cities through grantmaking and investing in arts and culture, education, environment, health, human services, and community development.

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PROJECT ORGANIZERS

The **Primary Care Development Corporation** (PCDC; www.pcdc.org) is a nonprofit organization dedicated to transforming and expanding primary care in underserved communities to improve health outcomes and, reduce healthcare costs and disparities. Our programs enhance access to primary care by offering flexible financing to build and modernize facilities, providing coaching and training to strengthen care delivery, and leading policy initiatives. PCDC partners with primary care organizations throughout the U.S. to adopt a patient-centered model of care that maximizes patient access, meaningful use of health IT, care coordination and patient experience, and emergency planning. Certified as a Community Development Financial Institution (CDFI) by the U.S. Treasury, PCDC has financed over 105 primary care projects valued at more than \$500 million, creating primary care access for over 755,000 patients.

CSH transforms how communities use housing solutions to improve the lives of the most vulnerable people. We offer capital, expertise, information and innovation that allow our partners to use supportive housing to achieve stability, strength and success for the people in most need. CSH blends over 20 years of experience and dedication with a practical and entrepreneurial spirit, making us the source for housing solutions. CSH is an industry leader with national influence and deep connections in a growing number of local communities. We are headquartered in New York City with staff stationed in more than 20 locations around the country. Visit csh.org to learn how CSH has and can make a difference where you live.

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EXECUTIVE SUMMARY

Poor health both contributes to homelessness and is exacerbated by prolonged periods of housing instability. Homelessness limits access to appropriate care, worsens pre-existing conditions, and adds new health challenges, causing many high-need homeless individuals to cycle between shelters, emergency rooms, hospitals, jails, and other institutions. Alternatively, supportive housing – affordable housing coupled with supportive services – is proven to help vulnerable people stay housed, improve their health, and stabilize their lives. While there is a robust body of literature that points to supportive housing’s efficacy, especially related to promoting housing stability, enhanced supportive housing models - linking supportive housing and community health providers - show even stronger outcomes, particularly around improving tenants’ health status and dramatically reducing their costly use of crisis and inpatient services.

To address the specific challenges faced by chronically homeless and medically vulnerable individuals and families, FQHCs, hospitals, behavioral health providers, other health providers and health plans, are increasingly collaborating and forming new partnerships to more effectively coordinate client-centered, integrated healthcare in an effort to improve outcomes and reduce costs for supportive housing tenants. There are a number of supportive housing/community health partnership models possible, including an FQHC co-located with a supportive housing development or care coordination between a nearby FQHC serving tenants of a supportive development or tenants in scattered-site supportive housing. FQHCs are particularly well positioned to meet the healthcare needs of this group, providing a comprehensive, affordable, and culturally sensitive source of healthcare. Despite positive outcomes from these partnerships, integrated health/housing models remain on the periphery of health systems. Much of this can be attributed to difficulties in working out how to link and coordinate their respective resources (capital, operating, and service) in order to fund such models.

Project Goals

The Primary Care Development Corporation (PCDC) and CSH are Community Development Financial Institutions (CDFIs) that share the same fundamental beliefs: that stable, affordable housing is a critical component of healthcare; and that the integration of housing and healthcare services is essential to improving peoples’ health and housing stability. With evidence of the effectiveness of the early health and housing coordination models, PCDC and CSH, collaborated to identify ways our resources and expertise can facilitate partnerships between FQHCs and supportive housing providers. With the support of The Kresge Foundation, we conducted an assessment of the environment in several states to determine the need and demand for lending or other financial tools to promote and expand FQHC coordination with supportive housing developments. To help identify ways our organizations can assist the field, we convened industry experts to explore both the challenges and the key factors that can foster greater opportunities for integration across the sectors.

The goals of this project were to: (1) better understand the environment around the country for integrating FQHCs and supportive housing; (2) gauge the demand for a financing program to enable this integration; and, if findings supported it, (3) create a business plan to develop and deploy a system for PCDC and CSH to jointly finance FQHCs and supportive housing facilities, which are co-located or in close proximity to one another.

Understanding the Landscape

In the initial assessment, CSH and PCDC reviewed internal analyses on supportive housing and healthcare industries, and surveyed published reports, literature, newspaper accounts and other internet-available materials. This review helped identify key indicators that: (i) demonstrate potential depth of market; (ii) sound capacity among providers to carry out housing and healthcare partnerships; (iii) existing state policy directives that represent support for healthcare and housing initiatives; and (iv) patterns of innovative partnerships among stakeholders at a level that would be sufficient for us to make an informed evaluation of that state's environment and potential for launching an integrated healthcare and housing initiative.

Within the states with strong CSH and PCDC presence, we ranked the states based on the most favorable environments, and we selected four states for in-depth Market Assessment, namely Arizona, California, Connecticut, and Oregon. We developed a questionnaire and interviewed key informants at 29 organizations, including government policy makers in healthcare and housing, primary care providers, supportive housing providers, and related national industry stakeholders.

To further explore the themes that arose from the assessment, and help identify ways each organization can assist the field, PCDC and CSH convened stakeholders from the healthcare and supportive housing sectors for a full-day structured discussion. The purpose of the convening was to:

- ❖ Understand the intersections between primary care and housing and the overlapping needs of these sectors' shared clientele;
- ❖ Share experiences about collaboration and partnership models;
- ❖ Discuss opportunities to align new and existing funding streams;
- ❖ Identify strategies to assist existing integrated models to improve and expand activities.

Findings

From our Market Assessment we concluded that before financing products could be most valuable, more immediate and fundamental needs must be addressed to position FQHCs and supportive housing providers to take integration to scale. The market assessment and subsequent convening highlighted a variety of issues and strategies in this effort to promote FQHC and supportive housing partnerships. PCDC and CSH are committed to improving conditions needed to expand FQHC and housing integration and believe fostering education and collaboration in the following areas will make a difference in the field.

➤ Share Promising Practices

The supportive housing population has complex needs and faces many barriers to obtaining care and remaining stably housed. Providers across the sectors have lessons to share regarding proper assessment of patient needs, building partnerships to address the wide array of client needs, improving how health providers, case managers and housing property managers communicate, and maintaining properly trained and supported staff. Promising practices can be shared to help service providers manage the fluctuations in service demands and associated revenue to assure financial viability. *CSH intends to use a recently awarded 3-year cooperative agreement grant from the Health Resources and Services Administration to deliver technical assistance and training to FQHCs looking to improve services and housing coordination for high-cost health system users. PCDC, through its technical assistance work, will continue to develop best practices to help community-based providers integrate services for vulnerable populations, including primary care, social services and supportive housing.*

- **Promote policies that support and integrate FQHCs and supportive housing**
 - Funding for healthcare and housing, especially federal funding, has different administrative rules, target populations, and reporting requirements making it difficult to integrate care between the systems. Federal agencies should look for creative ways to braid funding to help local organizations more efficiently access resources. In addition, state and local entities can use emerging policy examples to expand Medicaid reimbursable services to include services needed to maintain housing and case management. Federal agencies such as HUD and the Centers for Medicare and Medicaid Services (CMS) must also communicate to local and state decision makers that health and housing integration is a federal priority, which encourages innovation.
 - The diverse array of housing programs and associated issues with accessing affordable housing also create barriers to integrating health and housing programs. Communities are finding creative solutions to this ‘silo busting’ and using tools, such as memoranda of understanding and cross agency “community care teams”, to streamline how providers access housing and services resources and deliver coordinated services. These activities can help policymakers understand which rules and conditions of funding are important and which serve as a barrier to efficiently and effectively using these important resources.
 - Finally, new partners, including managed care organizations, public health departments, and affordable housing developers, are playing an increasingly important role in creating supportive housing. It is essential that these partnerships have access to resources like Low Income Housing Tax Credit and affordable housing subsidies, and are able to leverage services delivery models like health homes or accountable care organizations. *CSH and PCDC are committed to communicating these messages to policymakers. CSH is working with Congress to direct HUD and HHS to working more closely together to meet the needs of vulnerable individuals and families.*

- **Refine performance measurements and data sharing**
 - Policy and other decision makers, as well as FQHC and supportive housing partners, need data to show that programs are effectively meeting their goals. A supportive housing provider that only measures housing stability will have challenges engaging health partners if they are not also finding ways of tracking the supportive housing impact on the health outcomes of their residents. Health providers must not only measure health services, but understand the potential correlation between stable housing and positive health outcomes. Work is needed to help providers across the sectors to measure health outcomes and clearly articulate the specific supportive housing services that enable clients to achieve improved health outcomes. This requires commitment to tackle the hurdles to develop data sharing arrangements and identify mutual outcomes with health system providers. *Through CSH's frequent user demonstration initiatives, providers have overcome HIPAA to share enough client information for housing providers to target resources to the right person. In addition, lessons learned through CSH's Social Innovation Fund project will help give us lessons learned regarding collecting health outcome information in housing settings that can be distributed and replicated.*

- **Increase and re-align federal, state and local resources available for FQHCs, behavioral health, affordable housing and general support services**
 - There is no way to avoid the fact that both the health and affordable housing systems need increased resources targeted to vulnerable populations. FQHCs continue to be stretched to the limit as more people access clinic services and present with complex health conditions. This increasing demand makes it difficult for health centers to be encouraged to explore

new activities, especially if those new activities bring in harder-to-serve consumers. The housing system faces similar challenges, including difficulties finding affordable housing subsidies, flexible housing operating dollars, and capital resources to build new housing units. Many states and communities are taking the housing subsidy issue on themselves by creating subsidy programs such as vouchers to target to those with mental health and housing need using state behavioral health funding. *CSH and PCDC will share the results of this study with coalitions that advocate for funding access for supportive housing and FQHCs (including the Lenders Coalition for Community Health Centers), and will work with advocacy partners to expand funding for housing subsidies through HUD, and FQHC expansion grants through HRSA. CSH and PCDC will do more work to identify and promote innovative solutions.*

MARKET ASSESSMENT

Premise

Over the past year, the Primary Care Development Corporation (PCDC) and the Corporation for Supportive Housing (CSH) have collaborated on a project to explore capital development resource needs to advance development of healthcare and supportive housing partnerships. PCDC and CSH are Community Development Financial Institutions (CDFIs) that share the fundamental beliefs: that stable, affordable housing is a critical component of healthcare, and that the integration of housing and healthcare services is essential to improving peoples' health and housing stability. One successful model of this integration is through partnerships between supportive housing providers and Federally Qualified Health Centers (FQHCs). Through a grant from The Kresge Foundation, PCDC and CSH set out to determine the need and demand for lending or other financial tools to promote FQHC coordination with supportive housing developments.

Landscape

Poor health both contributes to homelessness and is exacerbated by prolonged periods of housing instability. Likewise, homelessness limits access to health coverage and appropriate care, worsens pre-existing conditions, and adds new health challenges. Stable housing provides a secure foundation for treating underlying health conditions and ensuring regular access to primary and preventive care. Absent stable housing tied to primary and/or preventive services, many high-need homeless individuals end up cycling between shelters, emergency rooms, hospitals, jails, and other institutions, never receiving treatment to address the persistent health challenges that can be the underlying causes of their homelessness and institutional cycling.

Supportive housing – affordable housing coupled with supportive services – is proven to help vulnerable people stay housed and stabilize their lives. While there is a robust body of literature that points to supportive housing's efficacy, especially related to promoting housing stability and reducing jail recidivism, enhanced supportive housing models show even stronger outcomes, particularly around improving tenants' health status and dramatically reducing their costly use of crisis and inpatient services. To address the specific challenges faced by chronically homeless and medically vulnerable individuals and families, a number of supportive housing providers and FQHCs have partnered in order to provide client-centered, integrated healthcare to supportive housing tenants.

FQHCs are particularly well positioned to meet the healthcare needs of this group, providing a comprehensive, affordable, and culturally sensitive source of healthcare. The model of care that FQHCs provide has demonstrated the ability to address both the complex chronic physical conditions and the underlying trauma and psychosocial factors that contribute to risky behaviors and involvement in crisis systems.

Nationally, efforts to reform the healthcare system and improve outcomes creates new motivations for primary care providers to target services to people with the most complex and costly health conditions and achieve the "triple aim" of reducing per capita healthcare costs, enhancing the quality of patient care, and improving health outcomes. FQHCs, hospitals, behavioral health providers, other health providers and health plans, are increasingly collaborating and forming new partnerships to more effectively coordinate patient care in an effort to improve outcomes and reduce costs. However, for some patients who are experiencing or are at-risk for homelessness, healthcare must be partnered with housing to ensure that the triple aim goals are achieved.

For example, a 2009 Chicago Housing for Health Partnership study found that adults with chronic illness discharged from local hospitals and placed in supportive housing with intensive care management had their health system costs reduced by 39%, which translated to \$25,000 per person, per year in savings.¹ Similarly, those living with HIV/AIDS achieved decreased viral loads and a 55% survival rate compared to 35% among the control group.² Studies in California, rural Maine, Denver, Seattle and other cities and regions have demonstrated similar results.

There are a number of supportive housing/community health partnership models possible, including an FQHC co-located with a supportive housing development or a nearby FQHC serving tenants of a supportive development or tenants in scattered-site supportive housing. Close collaboration between the care coordination and case management staff of the health and supportive housing providers is the foundation of any integration model.

Despite powerful positive outcomes, these enhanced supportive housing models remain on the periphery of health systems. Integrated health/housing models only exist on a small scale. Much of this can be attributed to difficulties in working out how to link and coordinate their respective resources (capital, operating, and service) in order to fund such models. There are additional barriers such as long project development timelines, complicated program requirements, and insufficient funding levels, when accessing mainstream programs such as Low-Income Housing Tax Credits, Section 8 or other housing vouchers, and Medicaid reimbursement.

Project Goals and Objectives

PCDC – a CDFI focused on FQHC financing, and CSH – a CDFI focused on supportive housing financing, collaborated to identify ways their resources can facilitate partnerships between FQHCs and supportive housing providers. The goals of this project were to: (1) better understand the environment around the country for integrating FQHCs and supportive housing; (2) gauge the demand for a financing program to enable this integration; and (3) if findings supported it, create a business plan to develop and deploy a program for PCDC and CSH to jointly finance community health centers and supportive housing facilities, which are co-located or in close proximity to one another.

Goal 1: Better Understand the Environment for Integration

- Objective 1a: Conduct an initial assessment to identify four geographic markets in which unmet demand and state policy were aligned to create a promising environment for a financing product. Primary targets of the geographic analysis included: (1) states in which PCDC and CSH had experience providing consulting and lending services; and (2) states with demonstrated high need for supportive housing and community health facilities.
- Objective 1b: Conduct a subsequent deeper Market Assessment of four states selected from the initial assessment to refine the extent and scope of the need for health centers and supportive housing in each geographic location, including assessing the local appetite for developing new integrated health/supportive housing projects, and/or adding a health center/services component to an existing supportive housing program.

Goal 2: Gauge Demand for Financing Program

¹ Sadowski, L., Kee, R., VanderWeele, T., & Buchanan, D. Effect of a Housing and Case Management Program on Emergency Department Visits and Hospitalizations among Chronically Ill Homeless Adults: A Randomized Trial. *Journal of the American Medical Association*. May 6, 2009, 301: 17, p. 1771.

² Buchanan, D., Kee, R., Sadowski, L., & Garcia, D. The Health Impact of Supportive Housing for HIV-Positive Homeless Patients: A Randomized Controlled Trial. *American Journal of Public Health*. June 2009, 99:6.

- Objective 2a: Improve our understanding of our target borrower and program model(s) for providing coordinated supportive housing and health services. This work would inform our thinking around who our target borrower is and the programmatic models we would want to jointly finance, based on our collective knowledge of industry best practice and underwriting guidelines.
- Objective 2b: Understand the existing landscape for financing integrated healthcare and supportive housing developments, with examination of borrower and project profiles, funding streams from state and local health and housing systems, and terms and conditions of capital available from conventional lenders and local or national CDFIs.
- Objective 2c: Gauge local receptivity to increasing enhanced supportive housing and determine competitive advantages of a PCDC/CSH collaboration by reaching out to potential target borrowers to understand their experience with integration models, challenges in accessing financing, key features of needed/desired financing, pitfalls to available financing options, and concerns or issues raised by local and national experts and stakeholders.
- Objective 2d: Refine our understanding of factors and conditions that would favor PCDC and CSH's success in jointly financing integrated health/supportive housing models in a given geographic area.

Goal 3: Develop a Business Plan to Create and Deploy Financing System

- Objective 3a: Move from Market Assessment to Business Planning around one or more specific lending products identified in the Market Assessment.

Methods

In the initial assessment, we reviewed CSH/PCDC internal analyses on supportive housing and healthcare industries, and surveyed published reports, literature, newspaper accounts and other internet-available materials. This review helped identify key indicators that we believe demonstrate potential depth of market, sound capacity among providers to carry out housing and healthcare partnerships, existing policy directives in the State that represent support for healthcare and housing initiatives, and patterns of innovative partnerships among stakeholders, at a level that would be sufficient for us to make an informed selection of states for inclusion in the in-depth Market Assessment. We added “diversity” factors to weigh geographic variety, demographic density, and level of state/provider sophistication as part of the mix. The key indicators are described in the box below.

KEY INDICATORS

Market Demand

- Medicaid – Medicaid indicators³ included coverage and enrollment levels, income eligibility criteria, and status of Medicaid expansion under the Patient Protection and Affordable Care Act 2010 and corresponding potential enrollment⁴ based on expansion.
- Homelessness – Using State reported Homeless Point-in-Time data for 2012⁵, analyzed sheltered and unsheltered populations, inventory of existing supportive housing units, and trends in availability of units over a three-year period.
- FQHC Coverage⁶ – Primarily focused on organizational capacity and client population by looking at the number of FQHC organizations and sites in each state, and the percent of state population served by FQHCs, both Medicaid-funded and uninsured.

Partnerships & Capacity

- Health and Housing Partnerships – Evidence of these partnerships was derived from the prevalence of State organizations participating in health home initiatives, CSH's Social Innovation Fund, or Medicaid Care Coordination Initiatives⁷; the experience in innovative research projects such as Medicaid Crosswalk analyses and Frequent User Cost studies; and State-developed Olmstead Plans.⁸
- Housing capacity and resources were ranked based on availability of set-asides, preferences or targeted resources for supportive housing, and depth and quality of the supportive housing provider network in the State.
- Sources for information on partnerships relied on internally reported CSH 2012 and 2013 Scorecards, CSH Social Innovation Fund target community scoring, and reports from the Kaiser Commission on Medicaid and the Uninsured.

Policy Direction and Support by Government Stakeholders

- Medicaid – Government direction related to Medicaid was assessed based on status of Medicaid expansion under ACA, potential changes in Medicaid Coverage eligibility and expanded benefit coverage under Section 1115 waivers.
- Housing Resource Allocation – Public resources and policies that supported supportive housing, as well as policies that sought to integrate supportive housing and healthcare services for low income residents.

Diversity

- Geographic Region/Density – prioritized selection of states in different geographic areas of the country and states ranging in population size and density.
- Sophistication and Expertise – consideration given to include states with a range of expertise and sophistication in partnerships and service delivery.

³ Kaiser Commission on Medicaid and the Uninsured, *Quick Take: States Getting a Jump Start on Health Reform's Medicaid Expansion*, April 2012 and

Kaiser Commission on Medicaid and the Uninsured, Report: *Medicaid Today: Preparing for Tomorrow. A Look at State Medicaid Program Spending, Enrollment and Policy Trends*, October 2012.

⁴ John Holahan, Matthew Buettgens, Caitlin Carroll, Stan Dorn (The Urban Institute), *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis*, Table ES-3, November 2012 published by the Kaiser Commission on Medicaid and the Uninsured.

⁵ HUD's 2010-2012 continuum of care Homeless Assistance Programs – Statewide Homeless Populations and Subpopulations and Housing Inventory Reports.

⁶ UDS Data from HRSA Website

⁷ Kaiser Commission on Medicaid and the Uninsured, Report: *Medicaid Today: Preparing for Tomorrow. A Look at State Medicaid Program Spending, Enrollment and Policy Trends*, October 2012

⁸ Terence Ny, JD, MA Alice Wong, MS & Charlene Harrington, PhD A Table of State Olmstead plans and related state activity UCSF National Center for Personal Assistance Services August 2011

Within the states with strong CSH and PCDC presence, we reviewed and ranked data from the key indicators based on their relevance to and measure of how favorable that state's environment might be for launching an integrated healthcare and housing initiative. We then compared states to rank those presenting the most favorable environments. Using this methodology, the states selected for in-depth Market Assessment were Arizona, California, Connecticut, and Oregon.

Once these four states were chosen, we moved on to the in-depth Market Assessment. Working with Fund Consulting, a firm with experience conducting market assessments for CDFIs, we developed an interview questionnaire, an electronic survey, and a set of prospective key informants to interview. Interviewees included 37 individuals from 29 organizations including government policy makers in healthcare and housing, primary care providers, supportive housing providers, and related national industry stakeholders. The interview questions probed stakeholders' knowledge of integrated health and supportive housing programs, the role of their organizations in integrating health and supportive housing programs, the challenges they face in these models and programs, and the resource needs they see when advancing the development of integrated health and supportive housing models. Responses to the electronic survey supplemented the interviews.

Findings

Most significantly, the Market Assessment results indicated that actual demand for large-scale capital financing requires greater cultivation. There exists a diversity of models, requiring greater focus on service coordination, satellite, or visiting healthcare models than on co-location per se. Service coordination and facilitation, and information technology were identified as the predominant resources needed. Additional key results found by PCDC and CSH included:

- The need for integrated healthcare and housing financing varies across the four states based on economic indicators, growth in target populations, and current and potential health and housing program policies.
- The range of models and partnerships for integrated healthcare and supportive housing is diverse and the typical "borrower" varies from supportive housing provider, housing developer, or healthcare provider. (*See further description of Models of Integration below*)
- Integrated healthcare and supportive housing projects have been funded by organizations piecing together existing housing or healthcare financing products rather than from an integrated financing product.
- Current policy changes are influencing how organizations may go about future integration.
 - While still recognizing the value of single-site supportive housing, in light of the Supreme Court's 1999 Olmstead Decision and general community de-institutionalization efforts, the target states are exploring alternatives including encouraging the development of smaller scale, mixed-income and scattered supportive housing options in addition to the site-based supportive housing model.
 - New opportunities for housing and health integration under the ACA and general health system reform are robust; however, in 2013, states and providers were primarily focused on early implementation of Medicaid expansion and other large system changes. Several of the target states are now exploring ways to expand Medicaid coverage for services in supportive housing and improve reimbursement rates and payment models to be adequate and efficient.
- While there are instances of organizations that have provided both supportive housing and healthcare services, it is likely that most future integration will be undertaken through inter-organizational collaboration, or by those organizations that have already expanded across the two sectors.

Models of Integration

As highlighted earlier, supportive housing is proven to help vulnerable people stay housed and stabilize their lives. The integration of supportive housing and FQHCs can address the specific challenges faced by chronically homeless and medically vulnerable individuals and families by providing client-centered, integrated healthcare. Circumstances that prompted individual providers to integrate these services included recognition of the high service intensity needs of clients, the dearth of affordable and supportive housing available in a given community, and a vision to create a coordinated system of care for clients.

There are different models for integrating supportive housing and FQHCs, which may vary depending on a range of factors. Integration of supportive housing and FQHCs can be provided within a single entity or through partnerships. The common thread of successful integration is the ability to make the connection between tenants' healthcare and housing.

Single-Entity Integration

An organization provides both housing and health services directly from within their single entity or related entities. This model is not widespread but can be effective for certain organizations. Agencies delivering both housing and primary care tend to be FQHCs, and more often, the subset of FQHCs that are designated by the Health Resources and Services Administration (HRSA), as Health Care for the Homeless providers (HCHs). HCHs must meet specific requirements that are not necessarily required of FQHCs serving the general population. Based on their target populations, HCHs must deliver substance use treatment services and have individuals with histories of homelessness represented on their boards. These entities recognized that housing stability can improve health outcome, and that there was a significant gap in the availability of affordable housing for the high need populations they serve. Given, their unique position at the intersection of housing and healthcare need for patients, several HCHs have incorporated a spectrum of housing options into their operations. These tend to be larger HCHs that sometimes operate separate housing and health entities under the auspices of one organization.

Partnership Integration

Integration of housing and healthcare is most commonly achieved through collaboration between distinct organizations with expertise in their respective fields. Due to the complexity of sector regulations and the overwhelming needs of clients, most existing providers, whether supportive housing or healthcare, are reluctant to expand into the other line of business. Future integration will likely be achieved through inter-organizational collaboration or in some instances through further expansion by organizations that are already providing services across the two sectors. While spreading the costs of care between two organizations is advantageous, in order to be successful, the partnership model requires significant effort from both agencies to understand each entity's role and responsibility and communicate regularly to maintain and advance the partnership. Best practices include effective means for sharing data and coordinating care for clients, including having efficient processes for referrals and follow up visits. Often providers will have joint case meetings so that the housing case manager can assist the health center staff in helping the resident adhere to care, attend appointments, and follow general doctor advice.

Whether provided by a single entity or through partnership, the service delivery models we present are similar, and in all cases, communication and coordination between property management, case management, and healthcare providers is essential to successful integration of services to ensure residents receive seamless care. We highlight three models of integrated service delivery: supportive housing with an on-site health center, supportive housing with an associated health center off-site, and mobile provision of medical services outside of a fixed facility.

On-Site Health Center Model

On-site FQHCs in single-site supportive housing are most effective and viable when services are available not only to the residents of that building, but also to clients of the organization's other programs and the community at-large. Providing access to the on-site center for those outside the building provides additional revenue generation to achieve sustainability. This model is typically used when the building serves a higher need population and integrates with the overall model of bringing support services to residents. Providing on-site medical services through an FQHC can benefit supportive housing tenants with mobility limitations that make receiving services in the community an obstacle to their care.

Location of an FQHC within a supportive housing building can be accomplished with new construction or through renovation in an existing building. To be successfully housed within a residential building, the center needs to be in self-contained space that can be directly accessed from the street for neighborhood patients and separately directly accessed by building residents. In addition, it needs to meet local zoning and building requirements, national life safety codes, as well as any state healthcare facility requirements. The nature of health center facilities is such that they have more intensive structural, electrical, plumbing and ventilation needs than are typical of residential housing, which can be a challenge for many existing supportive housing developments.

Off-Site Health Center Model

Another option for supportive housing providers is partnering with a healthcare provider already operating an FQHC in the immediate neighborhood or who can build a new health center in proximity to the housing. This model could serve people living in a single-site supportive housing building and/or scattered-site apartments. Connecting to an existing FQHC has the benefit of improving the existing facility's sustainability and increasing the residents' connection to existing off-site centers, which support the movement to de-institutionalize housing and allows for residents to engage with the community. The off-site health center model can also establish an anchor for broader community development initiatives.

On-Site Health Center Model

Skid Row Housing Trust

Skid Row Housing Trust in Los Angeles has been integrating medical clinics into their housing developments for over a decade. Most recently, the Star Apartments provides housing for chronically homeless who were also identified as high utilizers of emergency services by the LA County Department of Health Services (DHS). The building houses a medical clinic and offices for DHS housing and health coordination staff. The dynamic relationship with DHS provides coordination of care and funding for Skid Row Housing's on-site housing services staff, which has been key to achieving housing stability and improved health outcomes.

Off-Site Health Center Model

LifeLong Medical

Lifelong Medical created the LifeLong Supportive Housing Program (SHP) to bring health and social services into subsidized affordable housing for nearly 600 tenants at ten different housing sites within Alameda County, CA, as well as to residents living in individual subsidized units scattered throughout the County. Services provided at the sites are a collaborative effort involving LifeLong (service provider), housing owners and property management. The collaborative team works to address internal issues as well as interacting with funders, neighbors and local government.

Mobile Services Model

In addition to using formal clinic space, providers are increasingly taking medical care out of the clinic facility altogether and bringing services directly to those who need them. A provider might operate a mobile care service to bring primary care into the community through a healthcare team. A supportive housing provider could also contract with a health institution to have a physician, psychiatrist, or registered nurse make home visits to tenants, whether in single-site or scattered-site housing. Finally, a housing provider might contract with the FQHC to co-locate a case manager so that those services are on-site but not a full clinic.

Across each of the models, a set procedure for coordination and communication between the partners at all levels is essential towards achieving the integration goals.

Mobile Services Model

Boston Health Care for the Homeless Program

BHCHP provides access to highest quality healthcare for homeless men, women and children in the greater Boston area. BHCHP deploys a range of integrated healthcare and housing models with special focus on bringing healthcare to those that need it. Their mobile medical units brings staff to shelters, hospitals (targeting frequent users of emergency rooms) and a unique relationship with Downs Racetrack to bring regular health services to migrant workers.

CONVENING

Concept: Bring Leaders Together

The results from our Market Assessment indicated that more immediate and fundamental needs exist to position FQHCs and supportive housing providers to take integration to scale. To further explore the themes that arose, with the continued support of The Kresge Foundation, PCDC and CSH organized an integrated supportive housing and healthcare “Convening” of targeted stakeholders from the healthcare and supportive housing sectors. The group of participants included representatives from organizations including those already providing different integrated healthcare and supportive housing models, as well as those interested in pursuing integration.

Our anticipated outcomes from the Convening centered on: (i) examining the existing integrated models, the circumstances that fostered their development, and the opportunities and barriers that support or impede such developments today; (ii) identifying key components of a technical assistance curriculum that responds to the identified barriers and opportunities; and (iii) laying the groundwork for a favorable financing environment by promoting those factors that will advance the development of inter-organizational collaboration and lead to the creation of demand for specific integrated models and products. Foreseen topics included:

- Understanding the intersections and overlapping needs of these sectors’ shared clientele
- Shared experiences about collaboration and partnership models
- Opportunities to align new and existing funding streams
- Strategies to assist existing integrated models to improve and expand activities.

The Convening provided an opportunity for leaders from across the country, representing the two sectors and operating different models of integrated care, to come together and share their experiences, successes, struggles, and ideas around this work. PCDC and CSH called upon the health and housing expertise of Fred Karnas, Social Investment Officer with The Kresge Foundation, to help facilitate the meeting. What follows in this report is a summary of the conversation and key takeaways from the Convening.

“What We Heard”

We asked the Convening participants to present a ten minute introduction describing: (i) how they have been integrating primary care, behavioral health services, and housing or how they would hope to if not doing this already; (ii) what successes they have had; (iii) the main barriers or challenges they faced to this integration; and (iv) what opportunities exist for either implementation or growing the model. After each presentation, the other participants responded or asked follow-up questions, which generated lively discussion and an opportunity for people to share their experiences.

Many valuable issues surfaced throughout the Convening. Notably, a number of challenges came up repeatedly and seemed to resonate with participants whether they operate in the healthcare or housing sector, or across the two sectors. Amid this dynamic discussion, there emerged several themes that seemed to be at the core of the integration of FQHCs and supportive housing.

In this section, we present some of the challenges raised – by no means an exhaustive list - in order to create a picture of the environment in which providers are working. We hope that by shedding light on these challenges, and strategies to address them, that we can help interested providers see how they might successfully navigate as they work towards effective integration of healthcare and housing.

1. Complexity and Diversity of Service Needs

➤ Working with a High Needs Population

A challenge that came up repeatedly during the Convening was that of serving a population with a broad spectrum of needs. Clearly, many of the participants (housing and healthcare providers) work with a service-dependent clientele a large proportion of whom have significant health issues and long histories of homelessness and present with very high needs which require intensive long-term services in order for them to remain stable, both medically and in housing.

Aging in place requires an increased range of services. Beyond age alone, many older tenants come into supportive housing after having lived for many years on the street, which has a dramatic impact on their health and can belie their biological years in terms of their relative frailty. In order to make independent living possible for this population, programs need to provide a broad array of services including physical therapy, respite care, prescription drugs, behavioral health services, dementia care, nutritional counseling, and much more. Many supportive housing providers at the Convening indicated that they feel-equipped to provide the increased level of care and services needed for their aging tenants.

The prevalence of traumatic stress in the lives of individuals and families experiencing homelessness is extraordinarily high. Often these individuals have experienced on-going trauma throughout their lives in the form of childhood abuse and neglect, domestic violence, community violence, and the trauma associated with poverty and the loss of home, safety and sense of security. Trauma, in general and specifically in a medical context, can create additional barriers to receiving medical care in the community. Sometimes the conditions within the communities themselves can create challenges to receiving care. Neighborhoods with high levels of drug use and crime, for instance, can provide triggers to clients and impede their progress toward recovery and reintegration. Participants noted the importance of increasing education and training, particularly for clinical staff, around trauma and its impact in order to provide quality care for vulnerable patients.

➤ Matching Needs to Appropriate Housing/Service Interventions

While most participants agreed that permanent supportive housing was the optimal housing intervention for their highest need clients, many noted that there is also a cohort of patients that may require support transitionally or during a period of crisis. Participants expressed the need for a broader continuum of integrated health-housing options to ensure there are sufficiently diverse levels of care and that these settings are then available to meet clients' needs in the most appropriate and cost-effective way. In addition, systematic assessment tools or processes should be developed to match people to housing consistent with and appropriate for their specific level of need and/or risk. These models of care should not only target those people who are in crisis but should also acknowledge and intervene with people who are at-risk in order to prevent a medical or housing crisis from occurring.

2. Staffing

> Burnout

Although from different fields, there was concurrence among the participants that front-line staff are often insufficiently equipped to address the very complex and high intensity needs of a significant portion of the population they serve. This imbalance in skills and experience, coupled

with a general lack of resources to provide an infrastructure to train and support staff, has led to staff burnout and turnover as an ongoing challenge for health and housing providers alike.

Contributing to staff burnout is a growing expectation for providers to do more with less. Programs are expected to reach more people, provide more intensive interventions, and achieve increasingly more dramatic results for the same or often less money. These unrealistic expectations have a direct impact on front-line workers, stretching them thin and inevitably affecting the quality of care people receive. Equally significant, participants voiced their concern that as providers are pushed to cut or keep costs low, staffing standards may be lowered, and licensed positions are being eliminated in favor of hiring less educated and consequently less expensive case work staff. Given the high needs of the target population, participants expressed a desire for funders, particularly of service dollars, to recognize that restricting organizations' ability to hire licensed staff, positions them to be ill-equipped to manage the service intensity needed by chronically homeless clients. Uniform staffing standards in terms of experience and education is an important ingredient in quality of care.

➤ **Maintaining and Building Essential Staff Skills and Competencies**

Another essential skill for both healthcare and supportive housing staff, and which is not necessarily correlated with levels of education and experience, is their ability to connect and form trusting relationships with the people they serve. Patients/clients generally do better when they develop strong relationships with their care providers. Participants expressed their concern that in moving towards higher caseloads, telephone-based and more medically-focused care coordination, the opportunities to create personal relationships, and the resulting positive impact, will be diminished if not lost. As supportive housing providers attempt to adapt to the increased need to provide medical services to their clients by hiring licensed clinical staff, the concern is that they will gain staff with strong clinical skills, while potentially losing out on the kind of outreach and engagement skills that have historically fostered relationship-building between staff and clients in supportive housing.

On the medical provider side, it can be very difficult to find providers who are willing to work with this population. While primary care is integral, some people also require specialized care, and yet, gaining access to specialists can be particularly challenging – not only is there a limited number of specialists, there are even fewer who are willing to accommodate the range of challenges associated with serving this population, from missed appointments to behavioral issues.

3. Housing Affordability and Limitations

➤ **Limited Availability**

Uniformly, participants agreed, housing must be recognized and included as an essential part of healthcare that is made available to people if we hope to stabilize them medically. The housing needs of chronically homeless individuals – particularly frequent users of crisis systems - are often dire. The medical needs of this population often preclude discharges from hospitals because they are too frail to recover from an injury or illness on the streets or in a shelter. In nearly every community with supportive housing, access to units is severely limited with waiting lists that typically go out a year or longer. Central to the challenges providers face in getting their clients properly housed is the general crisis of affordability in housing. Even for clients who don't need long-term supports, there is not enough affordable housing, and they will never be able to afford market-rate housing. Reductions in housing vouchers and subsidies have made this situation worse. One participant described their success in bringing together an integrated team of health, housing,

and social service providers to get people connected with care, while citing, however, the limited availability of affordable housing as a constant barrier for their target homeless population.

› **Lack of Housing Variety**

In addition to the issue of affordability, participants noted two additional key barriers - insufficient housing quantity and variety to meet the spectrum of clients' needs. Depending on geographic location and local continuum of care funding priorities, some participants expressed a need for more transitional or permanent supportive housing while others identified affordable housing as being most in need. Participants also identified the need for a more comprehensive continuum of care that includes interim care settings for people who are not in immediate danger of harm as well as "bridge" care for those exiting medical or mental health crises. This includes medical respite facilities, medical detox and crisis residential centers that provide a bridge of care and housing for medically frail and/or psychiatrically unstable homeless individuals. Through strategic partnerships, health and housing systems can build an effective continuum of housing options that help mitigate the critical gap in the supply of supportive and affordable housing.

4. *Developing Partnerships*

› **Communicating Across Silos**

A frustration voiced by most participants at the Convening was the difficulty in developing partnerships and coordinating work between, and often even within, the various sectors involved in this work. Health, housing, and community-based organizations often operate in their own silos. There is a great deal of overlap in the people served by each of these silos, yet communication and coordination remain limited. Within the broad healthcare sector, barriers were identified between providers focused on medical, behavioral health, or substance abuse, and between types of institutional providers like FQHCs and hospitals. For the housing sector, barriers were noted between providers of affordable housing and those serving segments with special needs, e.g., non-elderly disabled, seniors, and veterans. Healthcare providers noted the difficulty in establishing and maintaining relationships and communication with so many different housing providers. The staffing structure, services provided, and populations served can vary widely from one supportive housing provider to another, which can be confusing and overwhelming for hospital and FQHC staff. In addition, health centers need to be able to achieve a level of patient volume that is sufficient to ensure their financial sustainability. Having some centralized point of contact or access into the supportive housing sector might encourage collaboration between healthcare and housing entities. Participants identified a variety of ways for providers to partner and collaborate, beginning with basic communication and coordination around shared service populations all the way up to formal partnerships that fully integrate FQHCs into supportive housing buildings.

Developing partnerships can be particularly challenging when trying to engage stakeholders who perceive little or no benefit or incentive, particularly financial, in collaborating. This issue was particularly prominent for the supportive housing providers in their attempts to work with hospitals and to some extent, FQHCs. For some, establishing consistent lines of communication with medical providers, for example through case conferences, has proven difficult; and others found that they were able to engage with hospital clinicians during an immediate patient crisis, but found the hospital unwilling to remain engaged after the patient had been discharged from the hospital. One housing provider shared their experience of losing a productive partnership with hospitals once Medicaid coverage was expanded based on the unrealistic belief that the expanded coverage removed the need for coordination and resources. Even when there is a willingness on

both sides to work together, the variance in language and culture across health and housing sectors can be another barrier to partnership. An ability to communicate and understand one another is essential for partnering and aligning cross-sector care delivery.

➤ **Operating Structures and Requirements**

Understanding the operating structure of the collaborating partners is an essential basic. One supportive housing provider described his unsuccessful attempt to partner with local healthcare providers to have a registered nurse or nurse practitioner provide medical care at his housing facility. The response from one of the medical providers at the Convening explained that clinicians often work in teams, deploying a variety of specialties and expertise, in order to address the whole picture of a patient. In this case, providers may believe that pulling one person out of the team would be inadequate to address the complex needs of this homeless population and would disrupt their own model of care. This exchange is a clear example of how both housing and medical providers need to understand and identify ways to adapt their existing structures and methods to allow for collaboration that still honors their respective standards of care.

Rigid program and funding requirements and regulations can also inhibit partnerships. The difficulty in meshing regulations and policies, notably at the state level, impedes the development of flexible programs that could better respond to needs and achieve greater impact. One example of this mismatch is the frequent inability to co-locate mental health and substance abuse services despite the high incidence of co-occurring mental health issues and substance use within the same population.

Supportive housing participants expressed their frustration in trying to bring clinical services into the setting that will best meet their tenants' needs. This frustration is, in part, an outgrowth of the practical operating limitations healthcare providers face when delivering services in non-standard, low-volume healthcare locations, as well as the current regulatory, medical liability, and reimbursement policies that restrict where, how much, and by whom healthcare can be delivered. Many clinicians cannot get reimbursed for care delivered outside of the clinic, or if they are reimbursed, it is often not at the enhanced FQHC rate. This can be a deterrent to healthcare providers considering working with supportive housing to provide on-site medical care.

➤ **Preserving Organizational Identity While Adapting to an Expanded Scope of Work**

As providers recognize the increasing need for expansion of scope of services, collaboration, and partnership, there is a general concern about maintaining organizational identities. In the current climate, providers need to stay consistent with their missions, identities, and functions, while adapting to major systemic changes that require a broader scope of service and collaboration with other organizations.

Supportive housing participants were especially concerned with staying true to the original supportive housing model and avoiding over-medicalization, even while they recognize and address the medical needs of their clients. In search of funding supports, including Medicaid, housing providers and organizations do not have experience in billing Medicaid and are concerned over losing the essence of permanent supportive housing as they try to adapt services to meet Medicaid parameters. Housing participants voiced the importance to them of identifying opportunities to retain, and pay for, the outreach and engagement strategies, tenancy support services and community integration activities that have been so critical to successfully serving this population and that have defined supportive housing as a distinct and comprehensive intervention.

Further caution was noted by participants, that with the continued push to include more and more services in one site, medical and mental health services in particular, there is a risk of unintentionally diluting the intent of supportive housing and creating an institutional setting. Supportive housing providers are especially wary of this in light of the 1999 Supreme Court ruling of *Olmstead v L.C.*, which seeks to eliminate unnecessary segregation of persons with disabilities. Providing comprehensive, client-centered care with the ongoing intention of moving clients towards increased independence and community engagement is essential as providers work to integrate their services.

Smaller organizations can feel particularly vulnerable amidst these changes as they struggle to carve a place for themselves at the table when dealing with larger entities. Housing and social service providers might feel dwarfed by hospitals and managed care organizations. It can be difficult to engage in partnerships that feel equal, create solutions, and function effectively for both when there is such a discrepancy in size and relative influence of partners.

5. Funding

➤ **Amount, Type and Duration of Funding Available**

It is no surprise that the most common challenge expressed by participants, across both sectors, was funding – the insufficiency of current resources, spending limitations set by funders for the types of services delivered, and the manner/setting in which they can be delivered. Current funding structures have very specific guidelines creating significant obstacles to efforts to coordinate and bundle services.

Supportive housing developments require three types of funding: capital funding for building/property development, operating funding to maintain building operations, and program funding to deliver client services. In some states, capital funding for new housing development is difficult to obtain, while in others, there is a dearth of operating and service dollars. In general, it can be difficult to finance housing projects without a commitment of long-term services funding. In particular, grant funding for services in supportive housing has decreased significantly over the past decade, compelling providers to either cut back on services or seek to leverage other mainstream funding sources – like Medicaid, Community Mental Health or Human Services funding – to fill the gap.

The duration of funding was voiced as a particular concern as some housing providers have found that typical grant-based funding for operations and services has a maximum term of 1-5 years. Yet, as discussed earlier, though many of the tenants that supportive housing providers serve will never be as independent as the general population, they can benefit from having some degree of supportive services throughout their lives, especially when layered onto medical and behavioral health services. Housing and service providers need to have a long term financial commitment for the work they are doing so they are not left on the hook when the funding ends and yet their tenants continue to require support services.

➤ **Medicaid Reimbursement – Challenges and Opportunities**

Given the challenges that come with grant-based funding, several providers at the Convening expressed a desire to learn more about how to leverage Medicaid dollars to support their service operations. While maximizing Medicaid to cover a broader range of services has potential, Medicaid billing presents its own challenges.

Two overwhelming challenges around billing Medicaid that participants identified were the limited types of services for which Medicaid will reimburse and the fee-for-service payment model. In

many states, housing-based services and supports, especially for those without serious mental illness or a developmental disability, are not Medicaid benefits and thus are not reimbursable. Even when the services are reimbursable, it is through a fee-for-service model where each individual service must be billed separately and usually in 15 minute increments. This structure incentivizes providers to see as many people as possible, and penalizes providers who serve people with complex needs that require multiple service interventions and more of their time.

Providers at the Convening did support replication of models by which they are reimbursed at a case rate. In a case rate, the services and supports for supportive housing residents are bundled together and either the state or the managed care entity pays the provider a flat per member, per month rate for them to deliver services. This approach has the dual benefit of allowing the provider to deliver services in a person-centered way, while increasing the potential to reduce administrative burden.

In general, there is a strong need for training resources and technical assistance to help supportive housing and healthcare providers, state policy program personnel, and managed care partners to understand Medicaid expansion and how to fit coordinated services into its reimbursement structure.

6. Performance and Outcome Measures

> Cost Saving as Primary Outcome

With current efforts to curb healthcare costs, providers are feeling pressured to improve people's health and housing outcomes while also demonstrating significant cost savings. Participants at the Convening expressed concern that the drive for cost saving will significantly diminish the resources available, especially for providers serving a very high need and medically frail population. These people will likely always be expensive to the system and an expectation of significant reduction in their healthcare costs may be unrealistic.

Participants agreed that, while it is important to reduce medically unnecessary healthcare utilization and inappropriate use of crisis services, cost savings cannot be the only measure that determines the success of a program or intervention. An appropriate measurement of program success would be around improved health outcomes, and creating opportunities to redirect resources for services (including a clear articulation of the specific services in supportive housing) that will achieve those improved health outcomes.

> Unrealistic Expectations for Immediate Success

The relatively recent recognition of the important role stable housing plays in an individual's health can create an expectation that once a person is housed, there should be immediate improvement in health and corresponding reduced medical spending. Practitioners across the two sectors agreed there is still a great deal of work and time that goes into improving clients' health once they are in housing. Even when medical costs are reduced, there is concern about how long the health system will pay for increased costs associated with providing ongoing supports after initial cost savings are achieved.

> Tracking Each Partner's Outcomes

Successful collaborations call for housing providers to target health outcomes and for health providers to more fully understand the role of supportive housing services achieving housing stability and how housing stability creates the opportunity to impact and improve health outcomes. Convening participants voiced the need for shared accountability and outcome metrics that align incentives across all sectors. This shared accountability would encourage providers to collaborate

based on an understanding of both the outcomes they have in common and those pertaining exclusively to the other sector.

Currently, health providers are driven by medical necessity and process-driven performance measures (e.g., the number of cancer screenings administered) rather than maintenance of health and housing stability. With the recent creation of Accountable Care Organizations, shared savings plans and other pay-for-success financing mechanisms, primary care providers and hospitals can set up mechanisms to realize incentives for producing better outcomes. However, these incentive systems currently do not apply for behavioral health and housing providers. If meaningful partnerships are going to work, every partner must have a stake in the outcome and an incentive to participate.

Ultimately, participants expressed the belief that funders played a significant role, and could help set the stage for alignment of performance standards. While funders today are currently asking for integration in practice, they are not yet driving it through their funding streams. Funder Requests for Proposals which outline their own specific outcome measures could be drafted to allow or encourage providers to adapt outcome measures in a way that will facilitate partnership across sectors. Opportunities for cross-sector funding demonstrations leading to aligned performance outcomes could provide practical guidance to advance integration of the sectors.

➤ **Data and Information Sharing**

Last, but certainly not least, the ability to share information is essential to enable providers to align performance and outcomes. Key data sharing challenges voiced by participants include: (i) individual organizations and sectors are at different stages of electronic systems adoption and use; (ii) multiple provider tracking and billing systems are being used that do not uniformly or easily communicate with one another; (iii) there are multiple reporting requirements that magnify providers' efforts, and multiple systems that are not linked; and, (iv) at a very basic level, there is a lack of a shared nomenclature to track individuals within and across providers and sectors, while still maintaining the confidentiality of individuals' information. Key to data sharing is the dedication of resources for data collection and synchronization from provider to provider and across sectors. Housing providers in particular need to develop data systems that will assist them in modifying their processes to achieve better outcomes.

Synchronization requires data systems that can "talk" to one another and identify matches. Suggested advancements included data matching between the HUD Homeless data systems (HMIS) and electronic health records systems in order to target services and resources for those clients and patients that cross the sectors. Opportunities to adapt systems to collect data across sectors, as well as collection of demographic data about homelessness would advance these coordination opportunities. The interaction forms used by many case managers do not ask for medical information and the medical forms do not ask about housing. With this increased need for sharing information among providers, there also needs to be continued mindfulness of HIPPA requirements for maintaining client confidentiality.

MOVING FORWARD

The market assessment and subsequent Convening highlighted a variety of barriers that need to be addressed before widespread FQHC and supportive housing partnerships can move forward. PCDC and CSH are committed to improving conditions needed to expand FQHC and housing integration and believe fostering education and collaboration in the following areas will make a difference in the field.

➤ **Share Promising Practices**

As the Convening illustrated, several community health centers are actively integrating primary care and stable housing through co-location, coordination among residential and community health centers in a community, and through implementation of creative staffing models to deliver services to supportive housing residents. While not always completely replicable, providers across the country can learn specific lessons and replicate elements of these programs.

The supportive housing population has complex needs and faces many barriers to care and remaining stably housed. Providers across the sectors have lessons to share regarding proper assessment of patient needs, building partnerships to address the wide array of client needs, improving how health providers, case managers and housing property managers communicate, and maintaining properly trained and supported staff. Finally, best practices can be shared to help service providers to manage the fluctuations in service demands and associated revenue to assure financial viability. *CSH intends to use a recently awarded 3 year cooperative agreement grant from the Health Resources and Services Administration to deliver technical assistance and training to FQHCs looking to improve services and housing coordination for high-cost health system users. Through this funding, CSH will be able to share best practices with providers and assist with developing new solutions for many of the challenges raised at the Convening. PCDC, through its technical assistance work, will continue to develop best practices to help community-based providers integrate services for vulnerable populations, including primary care, social services and supportive housing.*

➤ **Promote policies and partnerships that reduce barriers**

Healthcare stakeholders at all levels expressed frustration with the reality that funding, especially federal funding, has different administrative rules, target populations, and reporting requirements making it difficult to integrate care between primary and behavioral healthcare systems. The challenge increases when housing is added to the mix. The diverse array of housing programs and associated issues with accessing affordable housing creates a barrier to integrating health and housing programs. Communities are finding creative solutions to this ‘silo busting’ and using tools, such as memoranda of understanding and cross agency “community care teams”, to streamline how providers access housing and services resources for and deliver coordinated services to clients/patients. Publicizing these strategies can help policymakers understand which rules and conditions of funding are important and which serve as a barrier to efficiently and effectively using these important resources. New partners, including managed care organizations, public health departments, and affordable housing developers, are playing an increasingly important role in creating supportive housing. Sharing information and ensuring these partnerships are incentivized for distribution of resources, such as Low Income Housing Tax Credit and affordable housing subsidies, or targeting of services delivery models such as health homes or accountable care organizations is essential. *CSH is working with Congress to direct HUD and HHS to working*

more closely together to meet the needs of vulnerable individuals and families. Federal agencies should look for creative ways to braid funding to help local organizations more efficiently access resources. In addition, state and local entities can use emerging policy examples to expand Medicaid reimbursable services to include services needed to maintain housing and case management. Finally, federal agencies such as HUD and the Centers for Medicare and Medicaid Services (CMS) must communicate to local and state decision makers that health and housing integration is a federal priority and encourage innovation. CSH and PCDC are committed to communicating these messages to policymakers.

➤ **Refine performance measurements and data sharing**

Policy and other decision makers, as well as FQHC and supportive housing providers need data to show that programs are effectively meeting their goals. In addition, new partners must be able to see that any potential relationship will help achieve their goals. A supportive housing provider that only measures housing stability will have challenges engaging health partners if they cannot also help to find ways to track the supportive housing impact on the health outcomes of their residents. Health providers must not only measure health services delivery and impact, but understand the potential correlation between stable housing and positive health outcomes. Work is needed to help providers across the sectors understand what these measures should be and how to evaluate progress. This requires tackling the hurdles to develop data sharing arrangements, and identifying mutual outcomes with health system providers. *However, several providers have found ways to create memos of understanding or use other tools to share data and measure joint outcomes. Through CSH's frequent user demonstration initiatives, providers have overcome HIPAA to share enough client information for housing providers to target resources to the right person. In addition, lessons learned through CSH's Social Innovation Fund project will help yield lessons learned regard collecting health outcome information in housing settings that can be distributed and replicated to address this concern from Convening attendees.*

➤ **Increase and re-align federal, state and local resources available for FQHCs, behavioral health, affordable housing and general support services**

There is no way to avoid the fact that both the health and affordable housing systems need increased resources targeted to vulnerable populations. Community health centers continue to be stretched to the limit as more people access clinic services and present with complex health conditions. This increasing demand makes it difficult for health centers to be encouraged to explore new activities, especially if those new activities bring in harder to serve consumers. The housing system faces similar challenges. Stakeholders discussed difficulties accessing affordable housing subsidies, finding flexible housing operating dollars, and limited capital resources to build new housing units. Also heard through market assessment interviews and the Convening was the need to find long-term housing and service solutions for those with complex needs, even as their service needs change over time. *PCDC and CSH will share the results of this study with coalitions that advocate for funding access for supportive housing and FQHCs (e.g., the Lenders Coalition for Community Health Centers), and will work with advocacy partners to expand available funding both for housing subsidies through HUD and for FQHC expansion grants through HRSA. Many states and communities are tackling the housing subsidy issue on their own by creating subsidy programs, such as vouchers, to target to those with mental health and housing needs using state behavioral health funding. CSH and PCDC will do more work to promote innovate solutions such as this.*

APPENDIX

INTEGRATED HEALTHCARE AND SUPPORTIVE HOUSING CONVENING PARTICIPANTS¹ – APRIL 24, 2014

Valerie Agostino, Senior Vice President, Healthcare and Housing for **Mercy Housing**, a national non-profit organization, founded in 1981 by the Sisters of Mercy, Omaha in response to the affordable housing crisis in that community. Since then, Mercy has become one of the nation's largest nonprofit affordable housing organizations. Their mission is to create stable, vibrant and healthy communities by developing, financing and operating affordable, program-enriched housing for families, seniors and people with special needs who lack the economic resources to access quality, safe housing opportunities.

Michael Banghart, is the executive director at **Renaissance Social Services** in Chicago. Renaissance is a unique non-profit organization that connects those in need with housing that is safe, quality and affordable. After helping clients attain housing, Renaissance provides them with comprehensive, flexible, client focused support case management services. Partnerships with local healthcare and service providers build the flexible service delivery model that gives clients the opportunity to live on their own with the support they need to be successful. The goal is to empower the individual or family to become as autonomous from Renaissance and the social service system as possible.

Karen Batia, Ph.D., is the executive director of **Heartland Health Outreach (HHO)** and vice president of Heartland Alliance for Human Needs & Human Rights. She also serves as the CEO of Together4Health, a care coordination entity comprised of 34 organizations that include hospitals, and social service, primary care, and housing providers across Cook County. **HHO** in Illinois through its participant-centered health home, provides comprehensive, integrated care, including primary, oral and behavioral healthcare, a continuum of housing options, food services, nutrition counseling, substance use services, and interpretation. Each year, HHO serves more than 12,000 people throughout the Chicago metropolitan area through its health center, satellite clinic, and medical outreach services at more than 50 shelters and in partnership with two other health centers to provide suburban services.

Alan Bradford is the Vice President and Chief Operating Officer for Saint Joseph's Health System and **Mercy Care Services** based in Atlanta, Georgia. Mercy Care is a reliable provider of high quality integrated care for Atlanta's homeless and uninsured vulnerable populations since 1985. Mercy Care is a Federally Qualified Health Center providing primary care and an array of wraparound services including dental and vision care, radiology, prenatal education, behavioral health, HIV and homeless case management services through a network of five fixed sites and six mobile clinics providing medical care, with a mix of employed and volunteer physicians, dentists, dental hygienists, medical assistants, nurse practitioners, registered nurses and optometrists. In 2012, Mercy Care's clinics provided medical care to more than 12,000 individuals; 66% were experiencing homelessness.

Debbie Bretag has been the executive director of **Housing Options** since 2009. For 25 years, Housing Options, based in Evanston, IL, has had a mission to develop housing opportunities for individuals recovering from mental illnesses, provide a network of support services so that each person can live as independently as possible, and advance understanding of mental illnesses and the need for supportive housing for individuals with mental illnesses, so that individuals can do just that – make life changing choices. In recent years, Housing Options has successfully launched a number of initiatives, including a supported employment program, that have garnered

¹ Agencies and Titles for convening participants are accurate as of April 24, 2014

state-wide recognition and early success for participants with a move to a Housing First model, using harm reduction and trauma-informed care.

Alison Cunningham is the Executive Director of **Columbus House, Inc., based in New Haven, CT.**

Columbus House opened its doors in 1981 to serve people who are homeless or at-risk of homelessness by providing shelter and housing. Columbus House has shifted its focus from managing homelessness to finding the solutions to end it. The agency now includes a full continuum of services in various locations across Connecticut, including New Haven, Middletown, Waterbury and New London. The agency operates permanent supportive housing across the state, has a robust Rapid Re-Housing program, has been a model for SOAR services, and recently opened the first state-funded Respite Program in the state. Columbus House participates in a Social Innovation Fund Program which provides housing and services for high utilizers of medical services, and works with local hospitals and health centers to develop coordinated care for clients with chronic health conditions.

Barbara DiPietro is the Policy Director for the **National Health Care for the Homeless Council** and also is Senior Director for Policy at Health Care for the Homeless of Maryland. The National Health Care for the Homeless Council has worked since 1986 to eliminate homelessness by ensuring comprehensive health care and secure housing for everyone. The NHCHC believes that housing and health care are inextricably related. Their activities include training, research and publication of reports and newsletters, collaboration and policy advocacy in support of Health Care for the Homeless (HCH) programs and related projects across the country. Every year, the Council co-sponsors an annual conference where clinicians, advocates, educators, and people experiencing homelessness gather to attend workshops, improve practices, and cultivate relationships within the HCH community.

Rachael Duke is the Supportive Housing Program Director at **Home Forward**, formerly known as the Housing Authority of Portland, in Oregon. Home Forward is the largest provider of affordable housing in Oregon, providing a variety of housing options to low-income individuals and families: more than 6,000 apartments to rent, including approximately 1,980 units of public housing, and approximately 9,390 Section 8 rent assistance vouchers. As a Moving to Work public housing authority, Home Forward is afforded greater flexibility in the administration of their housing programs. Home Forward provides expanded services through partnerships with more than 100 community agencies in the public, nonprofit and private sectors, including efforts to link housing and health care. The organization's Aging at Home initiative and the Apartments at Bud Clark Commons are examples of Home Forward's innovative and comprehensive approaches to addressing homelessness.

Brenda Goldstein is the Psychosocial Services Director at **LifeLong Medical Care**, a community health center serving Berkeley, Oakland and Richmond, California. LifeLong Medical Care was started in 1976, as a senior health center and now delivers comprehensive medical, dental, mental health and social services through multi-site, federally qualified health center serving low income people of all ages. Services are designed for people who have difficulty accessing care through traditional paths due to factors such as lack of insurance, homelessness, or cultural and linguistic barriers. LifeLong also operates a nationally recognized Supportive Housing Program model of care serving dually diagnosed homeless adults.

Kelsey Louie is the Chief Operating Officer of **Harlem United Community AIDS Center, Inc.**, a community-based healthcare organization that began in Harlem and now serves clients throughout New York City. Harlem United Community AIDS Center utilizes a service integration model which provides access to quality: healthcare - primary care and dental services; supportive housing; HIV prevention and education; and support services using multiple access points to meet clients' holistic needs. Harlem United has expertise in serving people who are homeless and who also struggle with HIV/AIDS, poverty, substance use, and/or mental illness. The agency is designated as a Federally Qualified Health Center for the Homeless (FQHC-H), and

provides services to clients on demand and regardless of their ability to pay. Harlem United has developed a comprehensive “one-stop” scope of services that is responsive to the specific needs of the homeless population.

Patrick McGovern is the Director of Government Affairs for Gilead Sciences, Inc., headquartered in Foster City, CA. Gilead is a research-based biopharmaceutical company that discovers, develops and commercializes innovative medicines in areas of unmet medical need. Gilead's portfolio of products includes treatments for HIV/AIDS, liver diseases, serious respiratory and cardiovascular conditions, cancer and inflammation. Gilead works closely with healthcare providers to coordinate care and address the needs of patients.

Jim O’Connell, M.D., is president of **Boston Health Care for the Homeless Program (BHCHP)** and an assistant professor of medicine at Harvard Medical School. He is one of the founding physicians of the organization that has for 29 years retained a simple mission to provide or assure access to the highest quality health care for all homeless men, women and children in the greater Boston area. BHCHP now serves over 12,000 homeless persons each year in two hospital-based clinics (Boston Medical Center and MGH) and in more than 70 shelters and outreach sites in Boston. At BHCHP’s free-standing 104-bed Barbara McInnis House, the organization provides an innovative respite care program, including acute and sub-acute, pre- and post-operative, and palliative and end-of-life care. Boston's Hospitals have BHCHP as an alternative to emergency rooms and as a safe discharge place for vulnerable patients.

Sister Adele O’Sullivan, M.D., has been a member of the Sisters of St. Joseph of Carondelet since 1968, and is the founder and president of **Circle the City**, the first 501(c)(3) organization to open a Medical Respite Center for people experiencing homelessness in the metro Phoenix area. This 50-bed facility provides medical care, nursing services, case management and behavioral health services to men and women recovering from illness or injury following hospital discharge or referral from community service partner agencies. The case managers assist patients to secure ongoing healthcare and secure affordable housing options. This has resulted in approximately 75% of Circle the City discharges going to some form of stable living environment. Circle the City plans to expand its services into the out-patient arena, opening a fixed site near the Medical Respite Center where the community can refer persons experiencing homelessness for primary care.

Brenda E. Rosen is Executive Director of **Common Ground**, the largest provider of permanent supportive housing in New York City with nearly 2,800 units in 13 buildings. The core supportive housing program is complemented by two other services – transitional housing and community outreach. Common Ground works closely with community partners and governmental agencies. The Street to Home program is a City of New York sponsored outreach program to house homeless individuals living on the streets of Brooklyn, Manhattan and Queens. Annually, Common Ground’s various programs benefit approximately 4,000 unique low- and very low-income individuals, across a wide range of populations including: those living with severe mental illness; persons living with HIV/AIDS; youth aging out of foster care; indigent seniors; and veterans of the U.S. Armed Forces.

Rachel Solotaroff, MD, MCR, is Medical Director at **Central City Concern (CCC)** in Portland, OR, an agency providing comprehensive solutions to ending homelessness and achieving self-sufficiency. Founded in 1979, CCC has developed a comprehensive continuum of affordable housing options integrated with direct services including healthcare, recovery and employment. CCC currently has a staff of 600+ and serves more than 13,000 individuals annually. The Old Town Clinic, a designated Healthcare for the Homeless program, is a patient-centered primary care home, with an emphasis on providing integrated care for individuals with complex social, medical and behavioral health conditions. In the current environment of healthcare transformation, CCC continues to lead the country in creating an integrated and seamless continuum of care for vulnerable individuals within the Portland community.

Kelly Thomas is the Grants Manager for **Skid Row Housing Trust (the Trust)** formed in 1989 to address the rapid disappearance of affordable housing in Los Angeles’ Downtown community. Today the Trust is a

thriving non-profit housing developer and service provider, one of the largest in Southern California, with 24 properties offering affordable housing to 1,694 residents of Skid Row and the City of Los Angeles. The Trust provides comprehensive on-site case management and primary mental and physical health care to its residents. Within its buildings, the Trust offers a variety of community recreational and therapeutic activities, and staff members work closely with community partners to ensure solid linkages and referrals to education, employment and other specialized supportive services.

John Wall is the Supportive Housing Director of **Arizona Housing Inc. (AHI)**. AHI owns and operates 540 units of supportive housing for formerly homeless men, women and children. The AHI program models are designed to help formerly homeless individuals and families to end their homelessness and become more self-sufficient by providing quality affordable housing and appropriate supportive services. Case managers and resident service coordinators engage the residents through various community activities and voluntary services. The resident services team offers support and refers residents to community partners to provide the professional services. With the advent of expanded Medicaid in Arizona, AHI is in discussions to expand their relationships with community partners to bring medical services such as nurses, EMT's and telemedicine on-site to remove barriers to care and reduce the use of unnecessary emergency services.

Susan Wiviott was the Chief Program Officer at **Palladia**, a multifaceted social service organization in New York City that is active in the areas of behavioral health, supportive housing, and homeless and shelter services. Palladia operates 29 programs in upper Manhattan and the Bronx, serving over 2000 people a day and 14,000 clients a year. Palladia has 470 permanent housing units; it operates five shelters, including two shelters for victims of domestic violence, three licensed outpatient behavioral health clinics and three residential substance abuse treatment programs.

Alicia Woodsby is the Executive Director of The **Partnership for Strong Communities**, a statewide nonprofit policy and advocacy organization dedicated to ending homelessness, expanding the creation of affordable housing, and building strong communities in Connecticut. The Partnership's strategy is to engage civic and elected leaders to imagine, plan and execute effective change and to create a new paradigm of thinking about housing. Since its founding in 1998, the Partnership has successfully advocated for more than \$700 million in public funding in Connecticut which has helped build homes and created programs to end chronic homelessness. Efforts coordinated by The Partnership include creating "community care teams" to improve both funding and coordination of services across government and community agencies in Connecticut.

Sunia Zaterman is the Executive Director of the **Council of Large Public Housing Authorities (CLPHA)**, an association **that** supports the nation's largest and most innovative housing authorities by advocating for the resources and policies they need to solve local housing challenges and create communities of opportunity. CLPHA's nearly 70 members represent virtually every major metropolitan area in the country. Together they manage almost half of the nation's multi-billion dollar public housing stock, administer a quarter of the Housing Choice Voucher program and operate a wide array of other housing programs. CLPHA is an advocate for creative partnerships and works to preserve and improve public and affordable housing through advocacy, research, policy analysis and public education.

CONVENING ORGANIZERS

Fred Karnas, Social Investment Officer with the **The Kresge Foundation**, was the key facilitator at the Convening. The Kresge Foundation provided funding to PCDC and CSH for the Integrated Healthcare and Supportive Housing Market Assessment and Convening. The Kresge Foundation is a \$3 billion private, national foundation headquartered in Metropolitan Detroit, in the suburb community of Troy, that works to expand opportunities in America's cities through grantmaking and investing in arts and culture, education, environment, health, human services, community development and place-based efforts in Detroit. In 2013, the Board of Trustees approved 316 awards totaling \$122 million; \$128 million was paid out to grantees over the course of the year. In addition, Kresge's Social Investment Practice made commitments totaling \$16 million in 2013.

CSH transforms how communities use housing solutions to improve the lives of the most vulnerable people. CSH programs include lending consulting, training and technical assistance to help partners to use supportive housing to achieve stability, strength and success for the people in most need. CSH blends over 20 years of experience and dedication with a practical and entrepreneurial spirit, making it the source for housing solutions. CSH is an industry leader with national influence and deep connections in a growing number of local communities. CSH is headquartered in New York City with staff stationed in more than 20 locations around the country.

CSH Convening Participants:

Connie Tempel, Chief Operating Officer

Peggy Bailey, Senior Policy Advisor

Andrew Baldwin, Associate Director, Community Investments

Jane Bilger, Senior Program Officer

Janette Kawachi, Director of Innovations

Primary Care Development Corporation (PCDC) is a nonprofit organization dedicated to transforming and expanding primary care in underserved communities to improve health outcomes, reduce healthcare costs and disparities. PCDC programs enhance access to primary care by offering flexible financing to build and modernize facilities, providing coaching and training to strengthen care delivery, and leading policy initiatives. Since 1993, PCDC has partnered with primary care organizations throughout the U.S. to adopt a patient-centered model of care that maximizes patient access, meaningful use of health IT, care coordination and patient experience, and emergency planning. Certified as a Community Development Financial Institution (CDFI) by the U.S. Treasury, PCDC has financed over 105 primary care projects valued at more than \$500 million, creating primary care access for over 755,000 patients.

PCDC Convening Participants:

Ronda Kotelchuck, Chief Executive Officer

Nancy Lager, Director of Capital Investment

Tom Manning, Managing Director of Capital Investment

David Salsberg, Senior Grants Manager
